

November 16, 2004

Re: **MDR #:** M2-05-0279-01 **Injured Employee:**
 TWCC#:
 IRO Cert. #: 5055 **DOI:**
 SS#:

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REQUESTOR:

RESPONDENT:

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Neurosurgery and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- Correspondence 09/21/04
- Office notes 08/30/04 – 09/15/04
- Electrodiagnostic test 07/14/04

Information provided by Respondent:

- Correspondence

Clinical History:

The patient is followed for the right hand and wrist pain. He was injured on his job on _____. The patient had a right carpal tunnel release approximately 1½ years ago without improvement. Studies demonstrated that he had a C5 through C8 radiculopathy by EMG and nerve conduction velocity study.

Disputed Services:

MRI of the right wrist and hand.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that an MRI of the right wrist and hand is not medically necessary in this case.

Rationale:

At this time, there is no evidence of plain films, and due to the patient's hyperesthesia with pathological sensory evaluation, this demonstrates that the patient may have pathology in the wrist, which is very probably secondary possibly to a neuroma with the palmar branch of the median nerve. If there is bony abnormality, this can be seen with plain x-rays. The fact that his carpal tunnel did not improve his hand condition also leads to speculation that he could have a RSD-type symptoms with the increased pain. At this time an MRI of the right wrist is inappropriate.

Additional Comments:

The reviewer further recommends that the patient be evaluated with the standard x-ray of the wrist looking for any deformity, and that the patient be referred to hand surgery for evaluation. It also seems at this time that the patient should be further evaluated for his C5 through C8 radiculopathy, probably with MRI scanning of the cervical spine.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by _____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on November 16, 2004.

Sincerely,